TATEMENT OF DEFICIENCIES  ND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:			(X2) MULTII A. BUILDINI B. WING	PLE CONSTRUCTION	(X3) DATE SU COMPLE	16D
ME OF PROVIDER OR SUPPLIER APITAL CARE	HFD12-0074	STREET ADD. 2820 HART WASHINGT	RESS, CITY, S		03/21	1/2008
REFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
from 3/20/2008 three compliance with the initial licensure surfermales with varying in the facility. All fill be included in the findings were base home, interviews were	re inspection was colough 3/21/2008 to as e findings from the 2/2 yey. Two males and ag degrees of disability residents were selectively a sampling, and on observations at yith the GHMRP 'S side including the incidents.	nducted sess 14/08 four ties reside lected to The the group taff, and	(1 00 <b>0</b> )	GOVERNMENT OF THE DIS DEPARTMENT OF HEALTH REGULATION 825 NORTH CAPITOL ST WASHINGTON,	ADMINISTRATIO r., n.e., 2nd flo(	N .
January 31, 2008 a 2008. A random s selected from a por residents and two	survey was initiated and completed on Fe ample of three clients pulation of four fema males residents with retardation and other	bruary 4, e was le varying				
observations at the programs. Also the management and residential and day of habilitation and include the facility's system.  1024 3501.7 ENVIRONI SPACE  Each GHMRP shall outside recreation.	Il show that it can pro	day don a review s, to porting  OF  ovide	1024	All individuals have at least community recreational act month. These were document however the planned recreational to be located. In the home manager will make individual has a recreation their program book. The Quensure that there is a calendare at least 4 activities per the communication of the com	ivities per ented, ention calendar e future the sure that each calendar in MRP will lar and there	4/11/0

	EMENT OF DEFICIENCIES  LAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		R/CLIA VIBER:	A BUILDING		(X3) DATE SURVEY COMPLETED R	
		HFD12-0074		B. WING		03/21	
NAME OF P	ROVIDER OR SUPPLIER				STATE, ZIP CODE		
CAPITAL	CARE			FORD STE TON, DC 20		<u>-</u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO GROSS-REFERENCED TO THE APP DEFICIENCY)	NILD BE	(X5) COMPLETE DATE
1 024	Continued From pa	ige 1		1 024			
	GHRMP failed to enact measures to ensure its residents received consistent access to outside recreational activities for all Residents residing in the facility.						
	The findings includ	e:					
	On 3/20/2008, the Group Home for Mentally Retarded Persons (GHMRP) 's Quality Assurance Specialist was not able to provide any evidence that outside recreational activities had been arranged and/or scheduled for any of the six resident's of the facility. On 3/21/2008 the Program Coordinator (PC) failed to present any evidence that measures had been taken to ensure that all of its six residents had access to take part in outside recreational activities.						
1 042		ERVICE / DINING A	REAS	1 042			
	Modified diets shall	l be as follows:					
	(b) Planned, prepa who have received and	red, and served by ir I instruction from a d	ndividuals ietitian:				
	Based on observareview, the Group Persons (GHMRP received the proper meal preparations Residents residing The finding included 1. Resident #1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	-	nd record etarded t staff etion in I ent dated courage On		1. New documentation methodate to indicate number consumed. Staff have been hydration. In the future program coordinator and will check the fluid intake meal monitoring to ensurfluid intake for all individuals.	of fluids en trained te the the nurses e and do e adequate	3/24/08

AND PLAN	TEMENT OF DEFICIENCIES OPLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HFD12-0074		B, WING		03/21/2008
NAME OF P	ROVIDER OR SUPPLIER			1	TATE, ZIP CODE	
				TFORD STE		
(X4) ID PREFIX TAG	(FACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE COMPLETE
1 042	Coordinator (PC) indicated that the GHMRP's			1042		
	ensure that Reside fluids during each if her most recent lab abnormally elevate dehydration. At 4:5 presented data that Resident #1 what the data being amount of cups or consuming. There presented during that had received	necessary measure of #1 received at leasures. Record review of results indicated should be a results indicated should be a results indicated should be a results indicated should be as offered fluids on ecollected did not indicated ounces per day was no evidence on the survey to substantiary training or instruct to ensure Resident ments.	st Boz of revealed e had an ey, the PC cumenting each meal, cate the she 's file or tlate that ctions			
1056	09-03-07 recomme current dietary order ground texture, do fiber/liquid nutrition Observations on 3 Resident #1's foo Resident #2's. Repended seconds evening meal time file or presented dethat staff had receifrom the Nutritionis recommended "d	Nutrition Assessmended and supported or for "regular [diet] uble portions, and include applement 3 time (20/2008 at 4.49pm red portions were the sesident #1 was not os at any time during the survey to according to ensure Resident ouble portions."	the with creased es daily. evealed same as beerved to he dence on ubstantiate estructions #1 ' s	1 056	2. Staff have been trained or sizes and are now implem correct portion sizes per or Program coordinator, hom and nurses are doing week monitoring to ensure that a portions are served.	enting rders. e manager
1 036	Each GHMRP sha preparation and se care of equipment	Il train staff in the sto erving of food, the cla , and food preparatio y conditions at all tire	erage, eaning and n in order			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A, BUILDING	PLE CONSTRUCTION	(X3) DATE SURY COMPLETE	VEY D
		HFD12-0074		B. WING		03/21/2	2008
NAME OF P	ROVIDER OR SUPPLIER				TATE, ZIP CODE		
CAPITAL CARE 2820 H/WASHII			2820 HART WASHINGT	FORD STE	1020		
(XA) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO' CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(XS) COMPLETE DATE
1 056	Continued From page 3			1 056			
( 058	Based on observate facility falled to enameasures to ensure cooking and serving residing in the facility. The finding included During the environs at 4:17pm several stored in the cabin with food residue a addition, the cooking and baking pans in there was soiled pleabinets. She furting and dinner ware stocked end end stored evidence presente substantiate that sproperly care for a equipment as required. The Coordinator was in there was soiled pleabinets. She furting and dinner ware stocked end end stored evidence presente substantiate that sproperly care for a equipment as required.  3502.16 MEAL SE A review and considered in modification and considered in the cach represerbed a modification of the cooking and		w, the eccessary ons of tesidents  3/20/2008 being re found recooking red in the cooking ntained, so no cooking to to cooking red in the cooking r	) Q58	All dishes and cooking utensils been cleaned or replaced. Staff been trained on proper care of cand caring equipment.  The home Manager will do a maudit of kitchen equipment to mathematical equipment is clean and in prondition.	have cooking onthly	4/11/08
	This Statute is no Based on observa	t met as evidenced b tion and staff intervie	y: w, the				

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	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER)		A, BUILDING	PLE CONSTRUCTION	COMPLE	(X3) DATE SURVEY COMPLETED R	
		HFD12-0074		B. WING _		03/2	1/2008
NAME OF P	ROVIDER OR SUPPLIER			•	STATE, ZIP CODE		
CAPITAL	CARE		2820 HAR WASHING	TFORD STE TON, DC 20	0020		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		FÜLL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
1 058	Continued From pa	ige 4		1 058			
	measures to ensur Nutritional oversigh Resident #1)	et and enforce the ne e the proper and nec at for its residents. (E	essary				
<b>.</b>	The finding include		-1 -1-4-4			<u> </u>	-
	09-03-07 recomme adequate fluid intal 3/21/08 at 4:47pm, Coordinator (PC) in staff was taking the ensure that Reside fluids during each ther most recent lat abnormally elevate dehydration. At 4:1 presented data that hat Resident #1 what the data being amount of cups or consuming. There presented during the Group Home for (GHMRP) coordinal fluid intal processions.	Nutrition Assessment anded that staff "end ke (6-8 cups/day)". The facility 's Programicated that the GHI ancessary measure and #1 received at least meal. Record review or results indicated should be a softened fluids on ecollected did not indicated the proper overstand the proper overstand the proper overstand Resident #1 's insure Resident #1 's in	courage On MRP's se to st 8oz of revealed e had an ay, the PC cumenting each meal, cate the she 's file or tiate that Persons ight with		1. New documentation in place to indicate fluids consumed, been trained on hy the future the programment in the check the fluid into meal monitoring to adequate fluid into individuals.  2. Staff have been trained implementing considerations.	o number of Staff have dration. In ram e nurses will ake and do o ensure ke for all ained on are now ect portion	3/24/08
	09-03-07 recomme current dietary ord ground texture, do fiber/liquid nutritior Observations on 3 Resident #1 's foo Resident #2 's. R	s Nutrition Assessme ended and supported or "regular (diet) uble portions, and inchal supplement 3 time/20/2008 at 4:49pm nod portions were the sesident #1 was not obsist any time during the strains of the sesident #2 was no evice.	the with creased as daily. evealed same as bserved to he		sizes per orders. F coordinator, home nurses are doing w monitoring to ensu portions are served	manager and reckly meal are that correct	3/24/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		HED42-0074		B. WING_			R	
-1445-05-5		HFD12-0074	DYNEST AD	DESC CITY	PTATE TID ODDE		1/2008	
CAPITAL	PROVIDER OR SUPPLIER		2820 HAR	RTFORD STEET, SE GTON, DC 20020				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(KÖ) COMPLETE DATE	
1 058	flie or presented du that the Group Hon Persons (GHMRP) oversight with the N	ige 5  Tring the survey to su the for Mentally Retar coordinated the propositionist to ensure the double portions to	ded per Resident	) 058	·			
1 062	Dishes and eating t	RVICE / DINING ARE utensils shall be clea red to maintain their s	ned after	I 062	3502.20	<del></del>		
	This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to enact and enforce the necessary measures to ensure the sanitary conditions of all eating/serving utensils for all Residents residing in the facility.  The finding includes:  During the environmental inspection on 3/20/2008			All dishes and cooking uter been cleaned or replaced. been trained on proper care and eating equipment.  The home Manager will do audit of kitchen equipment that equipment is clean and condition.	Staff have of cooking a monthly to make sure			
	at 4:17pm several patterns in the cabine with food residue and addition, the cookin and baking pans with and/or rusted. The Coordinator was into 5:56pm and she incompared there was soiled placabinets. She furth and dinner ware she cleaned and stored evidence presented substantiate that the Retarded Persons in necessary systems.	plastic serving bowls at above the sink wer and dried grease stain ag surface of several as found to be extrer facility 's Program terviewed on 3/21/20 dicated she was not eates/bowls being storoel have been main properly. There were at the time of surve a Group Home for M (GHMRP) had enacted to ensure the properly and cooking and cooking	being the found this. In cooking mely worn  08 at the ware red in the cooking stained, s no y to entally ed the				4/11/08	
ta a Na Più-	ation Administration	essing and booking		<u>;                                    </u>	<del></del>	<b>-</b>		

	TEMENT OF DEFICIENCIES PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:			A. BUILDIN	FLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		HFD12-0074		B. WING _		03/21/2008		
NAME OF P	ROVIDER OR SUPPLIER		!	ADDRESS, CITY, STATE, ZIP CODE				
CAPITAL	. CARE	,	2820 HAR WASHING	TFORD STE TON, DC 20	EET, SE 0020			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SCIDENTIFYING INFORMA	FULL [	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
1 052	Continued From pa	ige 6		1062				
	equipment as required by this section.				,			
1.073	3503.3(b) BEDROO	OMS AND BATHRO	OMS	1073				
	following items for		t least the					
	Based on observatifacility failed to enameasures to ensure provided with clean Residents #4 & #6)  The finding include During the environment 3.18pm revealed and comforters we to be bodily fluids. Program Coordinative revealed she was reconditions of the pinome. [Reference	met as evidenced by ion and staff interview of and enforce the nate that its Resident's pillows. (Examples:	3/20/2008 s pillows opeared cility 's softmany s in the sanitary		3503.3(b)  All beddings for all individuals here washed. The home manage program coordinator will do week checks to ensure that all individual bedrooms have adequate and clerification.  3503.10	er and ekly lals an 4/5/08		
1 082	Each bathroom that equipped with toiler dispenser, soap for adequate lighting.  This Statute is not	MS AND BATHROO!  It is used by residents Itissue, a paper tower hand washing, a min  met as evidenced by ion and staff interview	s shall be el and cup rror and	I 082	All bathrooms now have cups ar dispensers. In future the home rewill do daily walk through and reaudits to ensure that all bathroom cups and dispenser.  The program coordinator will proversight to ensure that all individual have adequate supplies of cups a needed bathroom items.	nanager nonthly ns have ovide iduals		
Analth D.	tation Administration							

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDIN B. WING		— СОМРІ	COMPLETED  R			
	<del></del>	HFD12-0074				03/2	21/2008		
CAPITAL	PROVIDER OR SUPPLIER		2820 HAF	DDRESS, CITY, STATE, ZIP CODE ARTFORD STEET, SE IGTON, DG 20020					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SCIDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE		
. 1 062	facility failed to enameasures to ensure and properly stocked paper towels for all facility.  The finding include:  During the environment 3:33pm revealed bathrooms had cup dispensers. Intervien Residential Coordinates	ot and enforce the need to be all bathrooms are end with our dispense Residents residing in	aquipped rs and n the 3/20/2008 t's s 5:37pm	l 082					
(1 090)	maintained in a safe and sanitary manne	erior of each GHMR e, clean, orderly, attr	active,	{i 090}					
	Based on observation facility failed to enact	met as evidenced by on and staff interview ot and enforce the ne the provisions of thi ent.	v, the ecessary	·					
1	environmental inspe 3:10pm: 1. Resident #2 's	s: Ins were observed di ection on 3/21/2008 a hospital bed was inc cility 's Licensed Pra	perable.		3504.1  1. Resident #2's treplaced.	ed has been	4/15/08		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		R/CLIA MBER:	A. BUILDING	(X2) MULTIPLE CONSTRUCTION (X3) DATE COMM			
	<u>_</u>	HFD12-0074				03/2	1/2008
NAME OF PE	ROVIDER OR SUPPLIER		ľ		STATE, ZIP CODE		
CAPITAL	CARE		2820 HAR WASHING	TFORD STE TON, DC 20	0020	<u> </u>	
(X4) ID PREFIX TAG	ISACH DEFICIENCY	EMENT OF DEFICIENCIE MUST BE PRECEDED 6Y CIDENTIFYING INFORMA	FULL [	ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE		COMPLETE DATE
{1 090}	Continued From pag	je 8	_	{i 090}			
	Resident #2 was pre to risks of aspiration bronchitis. The facil maintenance of this equipment.	, gastritis, and histo ity failed to ensure t resident 's adaptive	ry of the		2. Repairs to the be- have been made wall joints have a repaired.	and the closet	4/15/08
	<ol> <li>There was water Resident #2's bedralong the floor to was were dark, fuzzy and</li> </ol>	oom. There were a ill joints in the close	ilso areas ts that		3. Water damage an in bathroom #1 h repaired.		4/15/08
	<ol> <li>In Bathroom #1, water damage and broken tiles were observed along the lower portion of the floor adjacent to Resident #2 's bedroom.</li> </ol>				4. Walls in Residen have been cleane disinfected.	- · · · · ·	3/24/08
	4. The walls near I smeared with a browwalk-thru, the Direct Resident #3 was know were not aware.	wn substance, Duri t Care Staff indicate own to smear his fe	ng the ed that eces and		5. The window in the dinning room will by .		4/30/08
	walls near his bed.  5. The small winder	ow in the door in the	e dining		6. All screens have in all the bedroom		4/11/08
	area was broken. The crack was covered scotch tape.	his was an exterior red with plastic bags		,	7. The garbage area thoroughly cleaned		3/20/08
	missing. The facility screens in all the wing.  7. The small wood garbage was overfly up over the garbage.	Resident #4 ' s room y failed to ensure th indows were in good ien area that house owing. The garbage e cans and food iter ound around the bas	at all the d shape. s the e was piled ns were	In future the home manager will conduct a comprehensive environmental audit on a monthly basis and all necessary repairs done in a timely manner.  The program coordinator will ensure that audit is done and all repairs done timely.			4/30/08
1 095	3504 6 HOUSEKEE	EPING		(095	, .		
	Each poison and ca	oustic agent shall be	stored in	<u> </u>	<u> </u>		

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPL IDENTIFICATION N  HFD12-0074			(X2) MULT A. BUILDIN B. WING _	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED R 03/21/2008		
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE	03/2	112000	
CAPITAL	. CARE		2820 HAR WASHING	RTFORD STEET, SE GTON, DC 20020				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SCIDENTIFYING INFORMA	ULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETE DATE	
1 095		ge 9 d shall be out of dire	ct reach	1 095				
	Based on observati facility failed to ena measures to ensure caustic agents.	met as evidenced by on and staff interview of and enforce the near the proper storage of the proper storage.	v. the cessary		See 3504.6			
	The finding include: (Reference citation				3504.7			
	3504.7 HOUSEKES No poisonous or ha in a food preparatio  This Statute is not in Based on observation facility failed to enace the environment of the finding includes  During the environment of the finding includes  During the environment of the finding includes  The finding includes  During the environment of the finding includes  The finding includes  During the environment of the finding includes  The finding includes  During the environment of the finding includes  The finding includes  During the environment of the finding includes  The finding includes  During the environment of the finding includes  The finding includes the f	EPING zardous agent shall to a storage or serving met as evidenced by and staff interview at and enforce the new that poisonous and/re stored or kept in a ment (kitchen).	area.  7, the cassary or food  8/20/2008 e being ity ' a 14pm agent ther	1 096	All cleaning agents have bee from the kitchen area and pla locked cabinet.  Home manager and program will perform daily walk throthere are no cleaning agents kitchen and home manager with monthly environmental audit that cleaning agents are prop	coordinator ugh to ensure in the vill do us to ensure	3/22/08	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLI. IDENTIFICATION NUMBER		R/CLIA MBER:	(XZ) MULTIPLE CONSTRUCTION A, BUILDING		(X3) DATE SURVEY COMPLETED	
		MFD12-0074		B. WING		R 03/21/2008
NAME OF F	ROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY,	STATE, ZIP CODE	V3/2 1/2QQB
CAPITAI	LCARE		2820 HAR WASHING	TFORD ST	EET, SE 20020	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
1 098	Continued From pa	ge 10	'	i 098		
890 !	8 3504.9 HOUSEKEEPING			1 098		
	procedures, person ensure sufficient cle	provide appropriate nel, and equipment is an linen supplies an hing and handling of each resident.	d the			
	Based on observation facility failed to ensure measures to ensure	met as evidenced by on and staff interview of and enforce the ne all Residents beddin linen. (Examples: F	v, the cessary ng are		3504.9	
The state of the s	at 3:18pm revealed and comforters were to be bodily fluids. I Program Coordinato revealed she was no conditions of the pill- home. The facility fa	nental inspection on 3 Resident #4 and 6 's e soiled with what ap nterview with the factor on 3/21/2008 at 3:5 of aware of the poor sows and bedspreads alled to ensure the pr	s pillows peared ility 's 77pm sanitary in the		All dishes and cooking utensils hat been cleaned or replaced. Staff he been trained on proper care of cooking eating equipment.  The home Manager will do a monaudit of kitchen equipment to make that equipment is clean and in proposition.	ave sking thly te sure  3/24/08
	washing and sanitar required by this sect	Were enacted to ensity conditions of the linion. [Reference the ditions cited in 3502.]	ien as citations	;	3504.10(b)  All dishes and cooking utensils ha	Ve
1 100	3504.10(b) HOUSE	KEEPING		1 100	been cleaned or replaced. Staff has been trained on proper care of cool	ave
	follows to each resid	provide clean linens a ent at least weekly:	as		and eating equipment.  The home Manager will do a mont audit of kitchen equipment to make that equipment is clean and in proceedings.	thly e sure
	(b) One (1) pillowcas	se;			that equipment is clean and in prop condition	per
	This Statute is not n	net as evidenced by:				

	TEMENT OF DEFICIENCIES OPLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A, BUILDING	·	(X3) DATE SURVEY COMPLETED		
		HFD12-0074		B. WING _	<u> </u>	03/21	
NAME OF P	ROVIDER OR SUPPLIER				TATE, ZIP CODE		1
CAPITAL	. CARE		2820 HAR WASHING	TFORD STE TON, DC 20	ET, SE 0020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SCIDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPRIDEFICIENCY)	ULD BE	(X5) COMPLETE DATE
1100	Continued From pa	ige 11		1 100		٠.	
	Based on observation and staff interview, the facility failed to enact and enforce the necessary measures to ensure the provision of clean linen/bedding to all Residents.			·	·		
	The finding include	s:	:				
	[Reference the cital conditions cited in 3504.1 & 3504.9]	tions of poor sanitary 3502.14, 3502.20, 35	, 603.3.				·
1108	3504.15 HOUSEKI	EEPIN <b>G</b>		l 108		. —	
,	Each GHMRP shall assure that each resident has at least seven (7) changes of clothing appropriate to his or her daily activities.  This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to enact and enforce the necessary measures to ensure its Residents were provided with an adequate supply of clothing. (Examples: Residents #1, #2,& #6)  The finding includes:				3504.15		
					All residents have had clothing in done. All individuals' who need additional clothing and shoes will assisted to go to the mall and pur needed items by.  Home Manager will conduct investigate at least 2 times a year and items purchased.  Program coordinator will provide	l be chase entory I needed	
	Observation on 3/20/2008 and again on 3/21/2008 revealed Resident #1, #2, and #6 had approximately one to two pairs of shoes, no casual and/or formal dress wear and none of the			oversight to ensure that bi-annual inventories are done and all indiventore adequate clothing.			
	clothing appeared interview with the f 3/20/2008 at 3:01p could be provided	properly coordinated facility 's Direct Care im revealed all three additional clothing ar better care of what w	Staff on residents at they				4/30/08

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE		(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HFD12-0074		B. WING		R 03/21/2008
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE	00/21/2000
ÇAPITAL	CARE			TFORD STI		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Tement of Deficiencie Must be preceded by SC identifying informa	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
1123	Continued From pa	ge 12		l 123		
l 123	3505.4(a)(1) FIRE	SAFETY	j	1 123	,	
	Each GHMRP shall have on the premises the following items:					
	approved by the Fir readily accessible to include the following (1) The instruct	and procedures that e Chief, which shall in o staff and residents g: ions and plans that a fire, explosion, or oth	be kept and shall are to be		3505.4(a)(1)  1. There is a disaster plan in plan however Capital Care administrate the process of creating a fire safet Training will be provided to staff	or is in Typlan.
	Based on observati facility failed to enarmasures to ensure manage the instruc- followed in case of emergency.	met as evidenced by on and staff interview of and enforce the ne a the provisions of a lions and plans that a fire, explosion, or oth	v, the ecessary policy to are to be			4/30/08
	(GHMRP) failed to p time of survey to su system and/or proto implemented to ensibeen met. Interview Residential Coordin	or Mentally Retarded present any evidence betantiate that the necessity in the highest that this requirer with the facility is ator on 3/21/2008 at the policy was not a	e at the ecessary d and/or nent had 6:23pm		There's a notification policy in the Emergency disaster policy. (see emergency disaster plan). Howev administrator will ensure that the	er the
	3505.4(a)(2) FIRE S Each GHMRP shall following (tems:	SAFETY have on the premise	es the	I 124	Fire safety Policy address notifical This will be completed by.	tion. 4/30/08

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD12-0074		A BUILDING B. WING 03/2		(X3) DATE SURVEY COMPLETED R 03/21/2008			
NAME OF P	ROVIDER OR SUPPLIER CARE		2820 HAR	ARTFORD STEET. SE ARTFORD STEET. SE AGTON, DC 20020			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETE	
l 124	approved by the Fit readily accessible t include the followin	and procedures that re Chief, which shall be staff and residents	be kept	12 <del>4</del>			
	Based on observat facility failed to enameasures to ensur address the persor fire/emergency.  The finding include The Group Home f (GHMRP) failed to time of survey to st system of notificati implemented to en been met. This po at the time of inspefacility's Resident	for Mentally Retarded present any evidence ubstantiate that the non had been created sure that this requirer licy requirement was ection. Interview with lat Coordinator on 3/2 hat part of the policy was	Persons e at the ecessary and/or ment had not met the 21/2008 at				
l 125	following items:  (a) Written policies approved by the Fi	Il have on the premisons and procedures that re Chief, which shall to staff and residents	t are be kept	i 125	3505.4(a)(3)  The administrator is in the proce developing policies that address of the alarm signals.		

		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		A, BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED R		
		HFD12-0074		B. WING	· · · · · · · · · · · · · · · · · · ·	4	1/2008	
NAME OF P	ROVIDER OR SUPPLIER				STATE, ZIP CODE			
CAPITAL	CARE			RTFORD STEET, SE GTON, DC 20020				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ALD SE	(X5) COMPLETE DATE		
1 125	1 125 Continued From page 14  (3) The location of alarm signals:			1 125				
		•						
	Based on observa facility failed to en- measures to ensu	It met as evidenced by ition and staff interview act and enforce the ne ire the provisions of a fied the location of ala	v, the cessary policy or					
	The finding include	es:						
	(GHMRP) failed to time of survey to a requirement had be requirement was re- inspection. This peat the time of inspe- facility's Resident	for Mentally Retarded or present any evidence substantiate that this men met. This policy not met at the time of solicy requirement was ection. Interview with tial Coordinator on 3/2 that part of the policy was of survey.	e at the not met the 1/2008 at					
1 126	3505.4(a)(4) FIRE	SAFETY		1 126			ļ	
	Each GHMRP sha following items:	all have on the premise	es the		3505.4(a)(4)			
	approved by the F	is and procedures that ire Chief, which shall to to staff and residents ng:	e kept		Written polices and procedures the approved by the Fire Chief are be developed and will be available to and residents.	ing l	·	
	(4) The location	ns of fire extinguisher	s;		The policy will include fire extinguishers.		4/30/08	
noth Page	Based on observat	t met as evidenced by tion and staff interview act and enforce the ne	, the					

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION  (X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SU COMPLE	TED	
		HFD12-0074		B, WING			1/2008	
NAME OF P	ROVIDER OR SUPPLIER	l	STREET ADD	RESS, CITY, S	TATE, ZIP CODE			
CAPITAL	. CARE		2820 HAR WASHING	RTFORD STEET, SE BTON, DC 20020				
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
l 126	Continued From pa	ige 15		I 126				
	posting which idented extinguishers.  The finding include  The Group Home f	or Mentally Retarded	re Persons					
	(GHMRP) failed to time of survey to surequirement had be requirement was nuinspection. This poat the time of inspectacility's Residentia	present any evidence obstantiate that this seen met. This policy of met at the time of plicy requirement was action. Interview with all Coordinator on 3/2 and part of the policy versions.	e at the not met the 21/2008 at					
l 127	3505.4(a)(5) FIRE	SAFETY		l 127				
	Each GHMRP shall following items:	I have on the premis	es the		3505.4(a)(5)			
	approved by the Fi	_	be kept		Written polices and procedures approved by the Fire Chief are I developed by the administrator include evacuation routes. This will be done by.	being	4/30/08	
	Based on observation facility failed to ename measures to ensure posting that identifies.	met as evidenced by tion and staff interview act and enforce the nate the provisions of a led the assigned avail of a fire/emergency.	w, the ecessary policy or cuation			l		
	The Group Home t	for Mentally Retarded	l Persons					
Strate &	tation Administration							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (DENTIFICATION NUMBER:			(X2) MULTIF A. BUILDING B. WING	· •••	(X3) DATE SURVEY COMPLETED R	
		HFD12-0074				03/21/2008
NAME OF P	ROVIDER OR SUPPLIER	-	i .		TATE, ZIP CODE	
CAPITAL	. CARE		2820 HAR WASHING	TFORD STE TON, DC 20	ET, SE )020	
(X4) ID PREFIX TAG	PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY PULL		FULL )	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETE
1 127	Continued From page 16			1 127	•	
	time of survey to si system had been e requirement had be requirement was n inspection, Intervie Residential Coordi	present any evidence ubstantiate that neces enacted to ensure that een met. This policy of met at the time of ew with the facility's natur on 3/21/2008 and the policy was not ey.	ssary at this at 6:31pm			
1 128	3505.4(a)(6) FIRE	SAFETY		l 128		
	Each GHMRP shall have on the premises the following items:  (a) Written policies and procedures that are approved by the Fire Chief, which shall be kept readily accessible to staff and residents and shall include the following:  (6) The frequency of fire drills;					
				3505.4(a)6  Written polices and procedures approved by the Fire Chief are be developed by administrator and include the frequency of Fire dr	peing Lwill	
	Based on observa facility failed to en- measures to ensu	t met as evidenced b tion and staff intervie act and enforce the r re the provisions of a frequency of fire dril	ew, the necessary n policy			
	The finding include	es:	-			·
	(GHMRP) failed to time of survey to a system had been requirement had to requirement was a inspection. Intervi- Residential Coord	for Mentally Retarded present any evidence ubstantiate that the renacted to ensure the peen met. This policy not met at the time of few with the facility standard on 3/21/2008 and of the policy was not	ce at the necessary at this y is set 6:33pm			

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AND PLA	AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD12-0074		er/Clia IMBER;	(X2) MU A. BUIL B. WINI	(X3) DATE SURVEY COMPLETED			
NAME OF	PROVIDER OR SUPPLIER	11121214	STREET A	EET ADDRESS, CITY, STATE, ZIP CODE				
CAPITA	AL CARE		2820 HA WASHING	D HARTFORD STEET, SE SHINGTON, DC 20020				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		MEL ALL L	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRINCED	DODE AAAAA		
1 128	Continued From pag	je 17	<u> </u>	1 128				
	at the time of survey	<b>,</b>	, .					
1 129	3505.4(a)(7) FIRE S	AFETY		1 129				
	This Statute is not meased on observation facility failed to enact measures to ensure the area of the area of the area of the area of the finding includes:	and procedures that Chief, which shall be staff and residents a staff of each shift; a at as evidenced by: a and staff interview, and enforce the neche provisions of a possignment of specific right staff across all staff across	are e kept and shall and the essary oficy c tasks shifts.		Written polices and procedures the approved by the Fire Chief are be developed by the administrator as include assignment of specific tast responsibilities of the staff on each Training will be implemented by.	ing nd will		
I 131 3	The Group Home for I (GHMRP) failed to pre lime of survey to substitute of survey to substitute of the survey that this require policy requirement was a spection. Interview vicesidential Coordinato revealed that part of that the time of survey.  1505.4(b) FIRE SAFET and GHMRP shall have a survey on Administration.	sent any evidence a tantiate that the property to been implemented ament had been met at the time with the facility 's on 3/21/2008 at 6:: e policy was not ava	t the per and to to of 36pm ilable	131	3505.4(b)  The administrator is working on ne policies and staff will receive approtraining to ensure that Fire safety measures are implemented by all states.	priate		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		R/CLIA MBER:	(X2) MULTIPLE CONSTRUCTION (X		(X3) DATE SURVEY COMPLETED	
		HFD12-0074		B. WING_		R
NAME OF E	RÓVIDER OR SUPPLIER	NFD12-0014	STORETAR	MARKE CITY	STATE, ZIP CODE	03/21/2008
WANT OF F	NOVIDER OR SUPPLIER			RTFORD ST		
CAPITAI	_ CARE			GTON, DC 2		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (CACH DEFICIENCY MUST BE FRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX YAG	PROVIDER'S FLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRICENCY)	JLD BE COMPLETE
l 131	following items:  (b) Records of the trare to perform the sithe manual describe subsection;  This Statute is not related to enact and record keeping.  The finding includes  The Group Home for (GHMRP) failed to processary training we ensure this requirem with the facility's Resident and 6:40pm.	raining of all personne pecific tasks designated in paragraph (a) of the personner of all staff training.	Persons at the oper and to Interview or on one of	131		
1 132	3505.4(c) FIRE \$AF	ETY		1132	<b>-</b>	
	3505.4 Each GHMR the following items:	P shall have on the p	premises		3505.4	
	(c) Records of fire in	spection reports;			Fire inspector performed an inspon January 31", but Capital Care have a report of the visit. Capital will contact the Fig. 1.	
	Based on observation facility failed to ensure measures to ensure	net as evidenced by: on and staff interview t and enforce the ne- the proper record ke of all fire inspection r	, the cessary eping		will contact the Fire Marshall an report to filed in the home.	1 Care diget the 4/30/08
esith Requis	ition Administration				··· <b>-</b>	

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (DENY)FICATION NUMBER:			A BUILDING		COMPLE	DATE SURVEY COMPLETED	
		HFD12-0074		B. WING_		03/21	/2008	
CAPITAL	ROVIDER OR SUPPLIER CARE		2820 HART	RESS, CITY, S IFORD STE ION, DC 20				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SCIDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	TVE ACTION SHOULD BE ED TO THE APPROPRIATE		
l 132	Continued From page 19			1 132				
	(GHMRP) failed to time of survey to su record keeping was requirement had be facility 's Residenti 6:45pm revealed si	or Mentally Retarded present any evidence obstantiate that the property of the prection report at the	e at the roper nsure this ith the 21/2008 at cate the					
1 133	3505.4(d) FIRE SAFETY			I 133				
	Each GHMRP shall have on the premises the following items:  (d) Dates of the test of alarm appliances; and  This Statute is not met as evidenced by: Based on observation and staff interview, the facility falled to enact and enforce the necessary measures to ensure the proper record keeping and documentation of all testing of alarm equipment.  The finding includes:  The Group Home for Mentally Retarded Persons (GHMRP) failed to present any evidence at the time of survey to substantiate that the proper record keeping was being enforced to ensure this requirement had been met. Interview with the facility 's Residential Coordinator on 3/21/2008 at 6:50pm revealed that there was no evidence that the alarm equipment had been tested as required		y; and  y:  w, the eccessary eeping  n  I Persons e at the roper nsure this ett/2008 at ence that		The test of the alarm appliances performed, however Capital car not have the report. Capital Carcontact Alarm works to get a coreport by.  In future, capital care will main and folder that holds all inspect alarm company.	e does te will ty of the	4/30/08	
(1 140)	3506.1(a) PROGRA	AM STATEMENT		{i 140}				
	2001 CI 1981 W 31101							

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VSUPPLIER/CLIA ATION NUMBER:	(X2) MULT A BUILDIN B. WING	IG	(X3) DATE SURVEY  COMPLETED  R  03/21/2008	
2820	TADORESS, CITY, HARTFORD STI HINGTON, DC 2	EET, SE		
ICIENCIES EDED BY FULL INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	DBE COMPLETE	
goals which following: lidents to be	{  140}	3506.1(a)		
hterview, the sthe necessard procedure approved by the phit committee	ne	Capital care now has a policy and procedure manual that has been re and approved by the administrator	viewed	
starded Perso vidence at the it the proper ed to ensure the facility failed the agency's and the number. Interview water on a section of the not available.	this co			
RES governin pe reviewed at	9	3507.2		
This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to enact and enforce the necessa measures to ensure the policy and procedure manual had been reviewed and approved by the	į	Capital care now has a policy and procedure manual that has been re and approved by the administrator	viewed	

measures to ensure the policy manual had been reviewed and Health Regulation Administration

		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		A. BUILDIN		(X3) DATE SURVEY COMPLETED R	
	·	HFD12-0074		B. WING_		03/21/2008	5
NAME OF P	ROVIDER OR SUPPLIER				STATE ZIP CODE		
CAPITAL	, CARE			TFORD STE TON, DC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMP	LETE
l 161	facility's administrator or oversight committee.  The finding includes:  The Group Home for Mentally Retarded Persons (GHMRP) failed to present any evidence at the time of survey to substantiate that the proper record keeping was being enforced to ensure this requirement had been met. This policy requirement was not met at the time of inspection. Interview with the facility's Residential Coordinator on 3/21/2008 at 6:01pm revealed the policy and procedure manual was not signed nor dated as being reviewed over the past certification year.			I 161			
(I.1 <b>6</b> 6)	, ,	S AND PROCEDUR neorporate policies are sat the following:		{I 166}			:
	records, administration confidentiality of reconfidentiality of reconfidentiality of reconfidentiality falled to enameasures to ensure procedure manual and analysis.	met as evidenced by ion and staff interview of and enforce the new that the current policed decided addressed the recording.	r: v, the ecessary icy and i keeping		3507.4(d)  Capital care now has a policy and procedure manual that has been and approved by the administrate	reviewed	/08
	(GHMRP) failed to time of survey to su system had been e	or Mentally Retarded present any evidence ibstantiate that the presented to enforce acuring this requirement.	e at the coper curate				

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		R/CLIA MBER:	3	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		HFD12-0074		A BUILDI	10	R 03/21/2008		
NAME OF F	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE	V-7-112000		
CAPITA	CARE			RTFORD STEET, SE GTON, DC 20020				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE  MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPRIDEFICIENCY)	ULD BE COMPLETE		
{I 166 <b>)</b>	been met. This pol at the time of inspe facility's Residenti	icy requirement was ction. Interview with al Coordinator on 3/2 at part of the policy w	the 1/2008 at l	{1 18 <b>6</b> }				
J 222	training programs s This Statute is not in Based on staff inter revealed the facility the necessary meas scheduling of staff to the finding includes Staff interview and increased the facility and necessary train to ensure the effections recommended in of all six residents. Residential Coordinate vealed the scheduling revealed the scheduling in the scheduling revealed the scheduling in the scheduling revealed the scheduling revealed the scheduling in the scheduling revealed revealed the scheduling revealed the scheduling revealed re	inuous, ongoing in-secheduled for all personnet as evidenced by view, and record revisited to enact and estres to ensure the raining.  Execord review on 3/21 failed to ensure the ping and supported to ve treatment and hall the Individual Service Interview with the factator on 3/21/2008 at alled trainings were not the time of survey efficient practice are	iew inforce  1/2008 proper the staff bilitation be Plans cility's 3:22pm	1 222	There's a training book and training schedule available. Staff has bee trained in a number of areas inclumedical, ISP goals and objectives infection control signs and symptiallness among many. There must been miscommunication as this wavailable in the home for review.	n ding s, BSPs, oms of have		
	and accurate record this section.	EPING: GENERAL ector shall maintain of and reports as required by:	uired by	1 260	See 3505.4(a)(1), 3505.4(a)(2), 3505.4(a)(3), 3505.4(a)(4), 3505.4(a)(5), 3505.4(a)(7),3505.4(5), 3505.4(b), 3505.4(c), 3505.4(d), 3507.4 and 3508.2.	4(a)(b),		
ealth Regula	idon Administration							

	STATEMENT OF DEFICIENCIES AND FLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		R/CLIA MBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HFD12-0074		B. WING			R 21/2008
NAME OF P	ROYIDER OR SUPPLIER	<u> </u>	STREET ADD	RESS, CITY,	STATE, ZIP CODE	1 03/-	4112000
CAPITAL	. CARE		2820 HAR WASHING	TFORD ST TON, DC 2	EET, SE 00020		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(XS) COMPLETE DATE
	Based on observatifacility failed to enameasures to ensure regulatory requirem. The finding included Reference the citati keeping as cited in 3605.4(a)(3), 3505.3505.4(b), 3505.4(c) and 3508.2.  3616.1 CONFIDEN Each GHMRP shall governing access to of information from consistent with D.C. 6-1972 and this characteristic review revealed the enforce the necessary confidentiality of all The finding includes It was observed on 03/21/2008 that all a personal habilitation open areas through Coordinator was into 3:48pm regarding thresponded by removauestion from off the further indicated that	ion and staff interview of and enforce the ries the provisions of the lent as evidenced be seen as evidenced be seen as evidenced by the provisions of the lent as evidenced by the provisions of the lent as evidenced by the provision of the lent as evidenced by the lent as evide	eccessary is	300	All postings in the facility that resident privacy policy have b removed. The new policies ar procedure manual address privical to resident records and In the future staff will be trainfollow policies and procedures adhere to privacy.	een  d  acy issues  privacy  ed to	3/30/08
	the resident spens	ALIEN MACHINER MA	- hosten	<del>]</del>	-	· <del></del>	<u> </u>

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		R/CLIA MBER:	(X2) MULTIN A. BUILDING B. WING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED R				
		HFD12-0074		03/21/2008					
NAME OF P	ROVIDER OR SUPPLIER	•		TADDRESS, CITY, STATE, ZIP CODE					
CAPITAL	. CARE			TFORD STE	DB20	· · · · · · · · · · · · · · · · · · ·			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SCIDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S FLAN OF I (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	COMPLETE DATE		
1 300	Continued From page 24			1300			,		
,	throughout the facility and would work to correct that deficient practice. Record review revealed there was no policy presented or on file at the time of survey to substantiate that there was any system in place to address the maintenance of Resident records.								
I 333	3517.11 ADMISSIO	ON POLICIES PROC	EDURES	1 333					
	No later than ten (10) days after the date of admission, the GHMRP director shall ensure that implementation of the Individual Habilitation Plan is begun for each resident who is admitted with an Individual Habilitation Plan.			,			,		
	This Statute is not met as evidenced by: Based on observation, staff interview, and record review revealed the facility failed to enact and enforce the necessary measures to ensure the habilitation and training of its Residents. (Examples: Resident #1 & #2)					,			
	The finding include	es:							
·	Record review on 3/21/2008 revealed all six of the residents had either medical or habilitative recommendations that were not being implemented. Examples of the falled implementations are as follows:								
	Resident #1 's Psychology Assessment 01- 09-08 recommended that the Group Home for Mentally Retarded Persons (GHMRP) implement the revised [behavior support plan] BSP with the following goal and objectives:     a. Goal: [Resident #1] will improve her behavior with a reduction in maladaptive incidents.			:					
	[	ent #1] will reduce inc							

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:			(X2) MULTII A. BUILDINI	(X3) DATE SURVEY COMPLETED					
		HED42-0074	•	B. WING	R 03/21/2008				
-:		HFD12-0074	STREET ADD	DRESS, CITY, 6	STATE, ZIP CODE				
CAPITAL	ROVIDER OR SUPPLIER CARE		2820 HAR	DDRESS, CITY, STATE, ZIP CODE RTFORD STEET, SE GTON, DC 20020					
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			. IO PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCEO TO THE APPRO DEFICIENCY)	LO BE COMPLETE			
1 333	1 .			1.333					
	non-compliance to consecutive month	3 (or less) per month s.	for 6		3517.11				
	of taking food item: consecutive month iii. Obj#3: [Reside	int#1] will reduce inc less) per month for (	in 6 Idents of		a) i. Objective has been implemented since the i of Capital Care on 2/1/0 See attachment. ii. Objective #2 was implemented on 2/1/08	nception 2/1/08			
	iv. Obj#4: [Resident #1] will reduce incidents of eating inedible/unsanitary items to 0 per month for 6 consecutive months.  v. Obj#5: [Resident #1] will reduce incidents of unhygienic practices to 5 (or less) per month for 6 consecutive months.		· ·	ii. Objective #3 was implemented on 2/1/08 iii. Objective #4 was implemented on 2/1/08 iv. Objective #4 was implemented on 2/1/08 V. Objective #5 was implemented on 2/1/08					
	none of these " re were being implem facility 's Program	3/21/2008 at 4:12pm vised " recommenda lented. Interview with Coordinator revealed recommendations.	tions : the		Program coordinator could not he stated that she was not aware of recommendations as she set up to program books and scheduled B training that was completed on	he			
	Quarterly dated 1/3 facility purchase at facility 's Program direct care staff on	s Physical Therapy (F 3/2008 recommended on the weights. Intervie Coordinator and the 3/21/2008 at 5:01pn on the weights anywh	that the www.th.the facility 's revealed		A new Physical Therapy assessing completed 2/7/08 and the exercic commended did not include weight See attached	ise			
1 334	3517.12 ADMISSI	ON POLICIES PROC	EDURES	1 334	,				
	of the Individual His recommendation r	tor shall, in the imple ablitation Plan, consi nade by the Interdisc with professionals or	der each Iplinary						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		MBER:	A. BUILDING	PLE CONSTRUCTION  3  BTATE, ZIP CODE	(X3) DATE SU COMPLET R 03/21	ED.				
	ROVIDER OR SUPPLIER		2820 HAR	2820 HARTFORD STEET, SE WASHINGTON, DC 20020						
CAPITAL		. <u></u>	<u> </u>	10N, BC 2	PROVIDER'S PLAN OF CORR	ECTION	()45)			
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIE BY MUST BE PRECEDED BY LSC IDENTIFYING INFORM	BUECFOFO RA BOFF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETE			
1 334	I 334 Continued From page 26 as necessary to ensure that implementation the Individual Habilitation Plan is accurate		ation of	1334						
	This Statute is not Based on observative revealed the enforce the necessary professing Resident 's half Resident #2)  The finding include the facility failed an effective system for all six of its resimplementation of An example of the Resident #2's Cassessment date the areas of dresmobility (transfer and tying shoe is assessment, the shared with the streview and interpolation of Resident #2 did supported in plasmareas of dressing her shoe laces.  In addition, the fithat a new Individual and Indi	ot met as evidenced bation, staff interview,	and record act and soure the plementing ple:  mentation of and oversight to the ce Plans. Interest to the ce Plans in actional to stand) expense in the and tying indicated as held on sives that over evidence on		Capital Care assumed the mathe house on 2/1/08. The net Occupational Therapy recording from assessment done 2/4/08 implemented. At the time of the OT assessment was not innew OT assessment is now of Program coordinator will entrecommendations are carried timely manner.  Quality assurance will conduct quarterly to ensure that all recommendation are implementation are implementation.	w nmendation is are being if the survey, in file. The on file. sure that all if out in a  lict an audit	4/1/08			

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NAME DE PROVINCE OR SUFFUEN		MBER:	A. BUILDING B. WING RESS, CITY, ST	ATE. ZIP CODE	(X3) DATE SURVEY GOMPLETED  R 03/21/2008		
CAPITAL			2820 HART	FFORD STEE FON, DC 200	et, SE )20		
(X4) ID Prefix Tag	SUMMARY STA	NTEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORM	FULL I	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (BACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	V1_D BE	COMPLETE DATE
(i 371)	from the 2/8/2008 being implemented 3519.2 EMERGEN Each GHMRP sha documentation that trained in carrying procedures set for This Statute is no Based on staff into revealed the facilit the necessary mer been trained to ca services outlined i The finding include Record review and Program Coordina revealed there wa had ensured the p its staff. There wa file at the time of o staff had been tra situations, includir missing persons, death as required facility's Program 4:17pm revealed available for revie [Reference the cit keeping as cited i 3505.4(a)(3), 350 3505.4(a)(6), 350	e revised recommentatividual Service Platas recommended.  ICIES  III maintain written at each employee has out the policies and the in § 3519.1 of this truet as evidenced between and record rely failed to enact and asures to ensure all arry out the provisions in the policies and provisions in the policies and provisions are provisions and provisions and provisions and provisions are provisions and provisions and provisions and provisions are provisions and provisions and provisions are provisions and provisions and provisions are provisions	s been section.  y: view enforce staff had acility 's spm se facility / training of ented or on that the rgency aster, uma, and r with the 1/2008 at was not ey, f record .4(a)(2), 5), 8),	(1 371)	All staff have been trained on pand procedures that address get disaster, missing persons, serio or trauma and death. In the fur program coordinator will make schedule is in place for all year in policies and procedure. QA will follow up to ensure the training is completed in a time!	neral us illness ure sure a ly training at all	4/30/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		R/CLIA VIBER:	(XZ) MULTI A. BUILDIN B. WING	PLE CONSTRUCTION	(X3) DATE SU COMPLET R	ED .		
	HFD12-0074		DETECT ADD	HEEE BITY	TATE TIP CODE	1 03121	/2000	
2820 HA				DRESS, CITY. STATE, ZIP CODE RTFORD STEET, SE STON, DC 20020				
(X4) ID PREFIX TAG	PREFIX (EACH OBFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			
1 402	Continued From pa	nge 28		1402			,	
l <b>40</b> 2	2 3520.4 PROFESSION SERVICES: GENERAL PROVISIONS			1 402				
	health inventory of		ļ		3520.4	٦		
1 404	This Statute is not met as evidenced by: Based on staff interview, and record review revealed the facility failed to enact and enforce the necessary measures to ensure all Resident's were provide with annual assessments as required by this section. (Example: Resident #5)  The finding includes:  Record review on 3/21/2008 revealed Resident #5's annual Neurology assessment dated 11/21/2007 was not completed due to the physician being away from office. Interview with the facility's Program Coordinator on 3/21/2008 at 5:18pm revealed there was no evidence presented or on file at the time of survey to substantiate that this annual assessment was completed as required by this section.		1 404	Capital care assumed management home on 2/1/08. The earliest neurology appoints could be made is scheduled for Washington Hospital Center. In future, RN will provide over ensure that LPNs are schedulin completing appointment in a time manner.	ment that 4/22/08 at sight to g and	4/22/08		
	PROVISIONS  Each professional service provider shall assist, as appropriate, each other person who is working with a resident in the GHMRP so that relevant professional instructions can be implemented through-out the resident's programs and daily activities.  This Statute is not met as evidenced by: Based on observation, staff interview and record							
	review, the Group	Home for Mentally R ) failed to ensure tha	letarded					

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NAME OF PROVIDER ON SOFFEICH			MBER:	A BUILDING B. WING RESS, CITY, S	TATE, ZIP CO		(X3) DATE SU COMPLE R 03/21	TED
CAPITAL	. CARE	,	2820 HART WASHINGT	FORD STE FON, DC 20	et, se 1020			
(X4) ID PREFIX TAG	/BACH DEFICIENCY	NTEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	(FACE	OVIDER'S PLAN OF CORRECT I CORRECTIVE ACTION SHO REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
1 4D4	meal praparations Resident #1)  The finding include  1. Resident #1 's 09-03-07 recomme adequate fluid intal 3/21/08 at 4:47pm, Coordinator (PC) is staff was taking the ensure that Reside fluids during each her most recent al abnormally elevate dehydration. At 4: presented data the that Resident #1 w but the data being amount of cups or consuming. There presented during t staff had received from the Nutritions fluid intake require  2. Resident #1 's 09-03-07 recomme current dietary ord ground texture, do fiber/liquid nutrition Observations on 3 Resident #1 's for Resident #2 's. R be offered second	r assistance and instrand provisions. (Example 1998)  Nutrition Assessment and that staff "end ke (6-8 cups/day)", the facility 's Programdicated that the GHI encessary measures that #1 received at leasures indicated shad BUN count due to 56pm on the same distributed and staff was do ras offered fluids on ecollected did not indiffuid ounces per days was no evidence on he survey to substan any training or instrust to ensure Resident	nt dated courage On ARP's es to st Boz of revealed ie had an ay, the PC cumenting each meal, icate the she's ifile or triate that ctions t #1's ent dated if the jwith creased es dally, revealed same as observed to the	1 404		New documentation m in place to indicate nur fluids consumed. Staff been trained on hydrat the future the program coordinator and the nur check the fluid intake meal monitoring to enadequate fluid intake findividuals.  New documentation min place to indicate nur fluids consumed. Staff been trained on hydrat the future the program coordinator and the nurcheck the fluid intake meal monitoring to enadequate fluid intake individuals.	nber of f have ion. In rses will and do sure or all method is mber of f have tion. In urses will and do sure	3/24/08
	file or presented d	luring the survey to surved any training or in	ubstantiate	· ·				

	MENT OF DEFICIENCIES AN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) A BUILDING			(3) DATE SURVEY COMPLETED		
		HFD12-0074		B. WING _	,		1/2008		
NAME OF P					STATE, ZIP CODE				
CAPITAL	. CARE		2820 HAR WASHING	RTFORD STEET, SE GTON, DC 20020					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE: MUST BE PRECEDED BY SCIDENTIFYING INFORMA	FULL	PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE		
l 404	Continued From pa	ge 30		1 404					
	from the Nutritionist recommended - do	t to ensure Resident puble portions "	#1's	:	·	·			
l 420	3521.1 HABILITATI	ON AND TRAINING		1 420					
	2 3521.1 HABILITATION AND TRAINING  Each GHMRP shall provide habilitation and training to its residents to enable them to acquire and maintain those life skills needed to cope				· .	•			
	more effectively wit	h the demands of the	eir	:	7504				
	environments and to achieve their optimum levels of physical, mental and social functioning.			; ;	3521.1				
	This Statute is not met as evidenced by: Based on staff interview, and record review revealed the facility failed to enact and enforce the necessary measures to ensure staff were effectively trained to implement a Resident's habilitation and treatment plans as recommended.				See 3519.2 and 3520.6				
	The finding includes	<b>s</b> :		· :			,		
	Staff interview and record review on 3/21/2008 revealed the facility failed to ensure the proper and necessary habilitative training and supported as required in the Individual Service Plans of six of its six residents. Interview with the facility 's Program Coordinator on 3/21/2008 at 4:08pm revealed she would work to ensure that staff are properly trained to implement the habilitation and treatment of its Residents. [Reference the deficient practices cited in 3519,2 and 3520.6]								
1 425		ATION AND TRAININ		1426					
		n at least every six (6		:					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION DENTIFICATION NUM			A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED R		
		HFD12-0074		B, WING _		03/21	/2000
NAME OF PROVIDER OR SUPPLIER STREET			STREET AOD	RESS, CITY.	STATE, ZIP CODE		ļ
CAPITAL	. CARE	<u>.</u>	2820 HAR WASHING	TFORD STE TON, DC 2	0020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OLD BE	(XS) COMPLETE DATE
l 426	Continued From page 31			1.426			
	(c) Is failing to progress toward identified objectives after reasonable efforts have been made;  This Statute is not met as evidenced by: Based on staff interview, and record review revealed the facility failed to enact and enforce the necessary measures to ensure the proper and necessary monitoring of a resident's habilitation and treatment as required by this section. (Example: Resident #1)  The finding includes:  Record review revealed Resident #1's Speech assessment dated 12/27/06 recommended the following:			:	3521.5(c)  Capital Care assumed managenthome on 2/1/08.	nent of	· .
·					All objectives were being done review and revisions. The new objectives from 2/8/08 have been implemented.  Program coordinator has discontinuous from the coordinator from the coordinator has discontinuous from the coordinator from the coor	goals and en ntinued	
·					objective to produce sign for ear cracker, shower. In the future Program Coordinate review objectives on a monthly revise as necessary.	ator will	4/1/08
	1. [Resident #1] should continue to receive training via the consultative model to improve her functional communications skills by increasing her sign language vocabulary.  2. Objective: [Resident #1] will produce 4 sign language vocabulary with 75% independence by 12/2007.  3. Short Term Objective: [Resident #1] will produce the manual sign for EAT, DRINK CRACKER, SHOWER with 50% independence for three consecutive months.						
	Record review and interview with the facility's Program Coordinator on 3/21/08 4:29pm revealed the "Short Term" objective has not been implemented to date. In addition, there was no evidence this program has been revised since it was written back in 2006 to address Resident #1's lack of progress. The data reflects that she fluctuates between refusing and requiring verbal prompt to complete the task and has been as such since the inception of the program.						

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULT	IPLE CONSTRUCTION	(X3) DATE S	
		HFD12-0074		B. WING			₹ 1/2008
NAME OF F	ROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY.	STATE, ZIP CODE		112000
CAPITAL			2820 HAR	TFORD ST	EET, SE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	(X5) COMPLETE DATE	
1 434	3521.7(d) HABILITA	ATION AND TRAINII	vG	1 434			
	The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas:				3521.7(d)	,	
	(d) Dressing (includ access to clothing);	ing purchasing, sele	cting, and	•	Capital Care assumed the manage the house on 2/1/08. The new		
	This Statute is not met as evidenced by: Based on staff interview, and record review revealed the facility failed to enact and enforce the necessary measures to ensure a resident received the necessary supports in the area of personal dressing.  The finding includes:  The facility failed to ensure that its Resident's are provided the opportunity to Improve their functional abilities in the area of dressing as cited in 3517.12.		:	Occupational Therapy recommer from assessment done 2/4/08 are implemented. At the time of the the OT assessment was not in file new OT assessment is now on file Program Coordinator will ensure recommendations are carried out	being survey, e. The e. that all		
				timely manner. Quality assurance will conduct an quarterly to ensure that all recommendation are implemented		4/1/08	
1 437	3521.7(g) HABILITA	TION AND TRAININ	1G	1 437			
	The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas:		by the , but not				
	(g) Communication (including language development and usage, signing, use of the telephone, letter writing, and availability and utilization of communications media, such as			3521.7(g)	»		
	books, newspapers, magazines, radio, television, telephone, and such specialized equipment as may be required);			See 3521.5(c)			
	Based on staff inten	net as evidenced by: /lew, and record revi failed to enact and e	ew			1	
ealth Regula	illon Administration	<del></del>		<u>·                                      </u>	<del></del>		

AND PLAN OF CORRECTION IDENT		(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	R/CLIA MBER:	(X2) MULTIP A. BUILDING B. WING	LE CONSTRUCTION	COMPLETED  R  93/21/2008			
		HFD12-0074				03/21	/2008		
NAME OF PE	ROVIDER OR SUPPLIER	,	STREET AOD	ADDRESS, CITY, STATE, ZIP CODE					
CAPITAL	CARE		2820 HAR' WASHING	RTFORD STEET, SE GTON, DC 20020					
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	r FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X6) Complete Date		
	received the necessormmunication.  The finding includes the facility failed to are provided the offunctional abilities as cited in 3521.5(  3521.7(k) HABILITY The habilitation and GHMRP shall include limited to, the finding and orient equipment);  This Statute is no based on staff interevealed the facility the necessary memobility.  The finding includes the facility failed the facili	esures to ensure a restary supports in the estary supports in the estary supports in the estary supports in the area of commercy.  ATION AND TRAIN of training of resident ends, when appropriate ellowing areas:  Ing ambulation, transplation, and use of must be ensured to ensure a restary supports in the estary supports i	area of  ident's their unication  ING ts by the te, but not sportation, obility  enforce esident area of	1441	a) i. Objective has been implemented since the of Capital Care on 2/1 See attachment. ii. Objective #2 was implemented on 2/1/0 ii. Objective #3 was implemented on 2/1/0 iii. Objective #4 was implemented on 2/1/0 iv. Objective #4 was implemented on 2/1/0 V. Objective #5 was implemented at the twas not aw recommendations as she sprogram books and sched training that was completed 2/7/08 and the commended did not incluse See attached.  Capital Care assumed the mathe house on 2/1/08. The new Occupational Therapy recomfrom assessment done 2/4/08 implemented. At the time of the OT assessment was not in new OT assessment is now o	e inception //08.  18  18  18  18  18  18  18  18  18	2/5/08		
1 445	functional abilities in 3517,11 and 35	pportunity to improve in the area of mobili 17.12. TATION AND TRAIN	ty as cited	1 445	Program coordinator will ens recommendations are carried timely manner.  Quality assurance will condu	sure that all out in a	·		
	The habilitation ar	nd training of residen ude, when appropria	ts by the		quarterly to ensure that all recommendation are implem	ented.	2/5/08		

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE	R/CLIA MBER:	1, ,	IPLE CONSTRUCTION	(33) DATE SURVEY COMPLETED		
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CAPITAL			2820 HAR	ARTFORD STEET, SE IGTON, DC 20020				
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1 445	Continued From pa	ge 34	·	1 445				
	This Statute is not Based on staff inter revealed the facility the necessary mea received the necess motor skills.  The finding includes the facility failed to are provided the op	eptual skills (including and fine motor skills) met as evidenced by view, and record revialled to enact and esures to ensure a restary supports in the second street that its Resignant the area of fine mo	); /: riew enforce sident area of		Capital Care assumed the manage the house on 2/1/08. The new Occupational Therapy recommen from assessment done 2/4/08 are implemented. At the time of the the OT assessment was not in file new OT assessment is now on file Program coordinator will ensure recommendations are carried out timely manner.  Quality assurance will conduct at quarterly to ensure that all recommendation are implemente	ndation being survey, e. The e. that all in a		
1458	Each resident's ac available to direct or daily.  This Statute is not Based on staff inter revealed the facility the necessary mea- of this regulatory re The finding includes Observation and sta and on 3/21/2008 re schedule available of implementation of hand/or community of Assurance specialis		be jed out  r: iew enforce provisions 3/20/2008 a sctivity cly sing	458	Individuals are given the opport have community outing. Outing documented, however on the da survey, the posted activity scheen not be located. There's a new seposted in the home. In future, the home manager will activity schedules and make surfiled in each individual's record Program Coordinator will follow ensure that there's a schedule an activities are carried out.	gs are te of dule could chedule il develop e they are s. w up to		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (DENTIFICATION NUMBER:			A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		HFD12-0074		B. WING _		03/21	/2008	
NAME OF I	PROVIDER OR SUPPLIER		2820 HAR	ADDRESS, CITY, STATE, ZIP CODE IARTFORD STEET, SE INGTON, DC 20020				
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFY[NG INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
1458	Continued From pa	ige 35		1 458			1	
	and the Program Coordinator wasn't able to present an activity schedule when requested on 3/21/2008.			:				
1473	3522.4 MEDICATION\$			1 473	3522.4			
	irregularities in the the prescribing phy This Statute is not Based on staff intervesled the facility the necessary meadocumentation and medication administration and medication administration and medication at the attending nursuredications that we crush/do not chew revealed there was to support the crus medications that w.  1. Depakote 500 2. Nexium 40mg 3. Ferrous Sulfate. 4. Dilantin 100m The medications with a small can omixed with a crust	t met as evidenced by riview, and record revy falled to enact and essures to ensure the direporting of errors is stration. (Example: Festivation of example: Festivation of the evening of e crushed Resident # rere labeled as "do not also as no physician" sord shing of the medication of the medication of the medication of the example of	mens to  y: y/ew enforce accurate n 3/20/2008 3 's not ter er on file ons. The ollows:		Resident #3's medications have been crushed per physician orders at the time of survey orders we current.  See attached Physician orders the in the home on 3/21/08.  Spilled medication is a medicate and medication nurses have been medication error policy. Nurentered a late note that indicates notification of RN supervisor as medical director.  In future RN will conduct medication nurses are following medication administration process.	ers. re nat were ion error, in trained rse id cation ure	3/21/08	

4108

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIE IDENTIFICATION NO				(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED R			
HFD12-0074				a, wing			1/2008		
NAME OF	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	TATE, ZIF CODE				
				RTFORD STEET, SE STON, DC 20020					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	(XS) COMPLETE DATE			
1473	Continued From page 36			1 473					
	Keppra, 125mg tab of Carvedilol, and 30cc of Lactulose. The mixture proved too much for the small can of Nepro and the nurse poured the excess in a small plastic cup which she indicated would be administered "at bedtime." As she prepared the medication tray to leave the nurses office, she bumped against the door and spilled the can of the medication mixture over the counter on her hand. She wiped up the spillage and administered what was left in the small can to Resident #3.								
	at 6:33pm they indi- labeled as don't corrush the medication primary care physic substitute if one was revealed that the remedications are critake well to anythin that reason they chaddition, the nurses destroying of medical	ras interviewed on 3/2 cated if a medication rush or chew they won and would ensure cian would order a liques needed. The nurseason Resident #3 's ushed was because Ing "solid" in his moush his medications, is indicated that any social with the Registered care Physician.	was ould not the uid es also the did not uth; for In pillage or umented						
	no physician 's ord the nurse falled to Nursing Notes), the PCP was notified o nothing presented Resident #3 was be dosages due to the and split across tw	A/21/2008 revealed the to crush the medical document the spillage and the spillage administered the medical documents of the spillage o	cations, e (MAR or RN) or ere was ate that e correct dissolved s.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER:			R/CLIA MBER:	A BUILDING		COMPLE	(X3) DATE SURVEY COMPLETED R		
HFD12-0074						1/2008			
NAME OF P	ROVIDER OR SUPPLIER	_		ORESS, CITY, STATE, ZIP CODE					
CAPITAL	. CARE			TFORD STEET, SE TON, DC 20020					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CO (BACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	E ACTION SHOULD BE COMPLET TO THE APPROPRIATE DATE			
1 500	3523.1 RESIDENT'S RIGHTS			1 500		·			
• .	Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws.  This Statute is not met as evidenced by: Based on observation, staff interview, and record review revealed the facility failed to enact and enforce the necessary measures to ensure client 's rights as presented in the following citations:  The findings include:  The facility failed to ensure an effective implementation of client 's rights to medical and habilitative care as presented in citations 2502.2(b), 3502.16, 3503.3(b), 3504.9, 3504.15, 3515.1, 3517.11, 3517.12, 3521.5(c), 3521.5(d), 3521.5(g), 3521.5(k), 3521.5(o), and 3622.4,								
				. ,	3523.1				
					See 2502.2(b), 3502.16, 33 3504.9, 3504.15, 3515.1, 3 3517.12, 3521.5(c), 3521.3 3521.5(k), 3521.5(o) and 3	517.11, 5(d), 3521.5(g),			
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